Part 5
Troubleshooting Denials/Claim Rejections

Proper payment of Medicare claims is a result of the joint efforts of the physician, other clinicians, the supplier, and billing personnel. This goal requires meeting the Medicare payment contractor's payment policy requirements that combine national and local policy. This section introduces common claim errors that result in claim rejections or claim denials and describes the general requirements for properly resubmitting rejected claims or appealing a denied claim.

If a claim is not paid as submitted, there are three general types of deficiencies identified by the Medicare payment contractor:

- Billing/data entry errors;
- Noncompliance with coverage policy; and
- Billing for services that are not medically necessary.

In many cases, the claim either could not be paid as initially submitted, or was denied because the payment contractor required additional documentation or a correction to the claim data.

WHAT CONSTITUTES A BILLING/DATA ENTRY ERROR?

Billing or data entry errors are generally described as errors and/or omissions contained within the Form CMS-1500 claim form itself (or the electronic claim equivalent). Omissions generally indicate that required fields were left blank [e.g., no International Classification of Disease - Ninth Edition, Clinical Modification (ICD-9-CM) diagnosis code entered in Item 21 of Form CMS-1500]. Errors could occur in situations where improper code numbers are entered, such as a nonexistent or retired Health Care Common Procedure Coding System (HCPCS) code.

Acceptable Electronic Claim Formats

Electronic claims must be in National Standard Format (NSF) or American National Standards Institute (ANSI) format. After HIPAA requirements become effective for a provider, electronic claims MUST be in ANSI X12N format. For a crosswalk of paper claim items to the corresponding NSF and ANSI electronic claim fields, refer to the *Medicare Claims Processing Manual*, Chapter 26, Completing and Processing Form CMS-1500 Data Set, available at http://www.cms.hhs.gov/manuals/104_claims/ on the Web. This crosswalk is also included within Reference C.

Errors could also occur when the procedure and diagnosis codes on the claim form do not match the clinical documentation (transposition errors). Most claim documentation errors are identified by the payment contractor's automated systems; however, incorrect entry of the following billing/data entry information pertaining to Part B physicians and suppliers often results in claim rejections and can also result in claim denials:

- Beneficiary name/Health Insurance Claim Number (HICN)/Sex;

- Billing provider;
- Diagnosis;
- Late filing;
- Modifiers;
- Performing provider number;
- Place of Service (POS) code;
- Procedure code;
- Quantity billed; and
- Unique Provider Identification Number (UPIN).

Each data entry error is described in the following tables and suggestions are provided for resolving the issue. Table 5-1 contains common billing errors affecting Part B physicians and suppliers.

HOW ARE COVERAGE POLICY COMPLIANCE ISSUES IDENTIFIED?

Payment contractors may identify errors in coverage policy compliance by utilizing automated systems that use logic programming to match code combinations (e.g., ICD-9-CM codes with HCPCS codes), or through manual Medical Review (MR). Coverage policy denials are supported in statute under Section 1862 of Title XVIII of the Social Security Act.

Table 5-1. Common Billing Errors Affecting Part B Physicians and Suppliers.

Beneficiary Name/Health Insurance Claim Number (HICN)/Sex Error:
The Medicare beneficiary name, (HICN), and sex are required information. This information is often incorrect for the following reasons: ❖ The Medicare beneficiary's name is misspelled or does not match the eligibility file; ❖ The Medicare beneficiary's HICN is incorrect, incomplete, or missing; or ❖ The Medicare beneficiary's sex is incorrect or missing.
Resolution:
1. Verify the Medicare beneficiary's name, HICN, and sex against the red, white, and blue Medicare health insurance card. 2. Enter the Medicare beneficiary's first and last name in Item 2 of Form CMS-1500 or the electronic claim equivalent (see Reference C). The name must be alphabetic. 3. Enter the HICN in Item 1a of the Form CMS-1500 or the electronic claim equivalent (see Reference C). The nine characters must be numeric. The 10th character must be alphabetic (no space). The 11th and 12th characters must be alpha-numeric (no spaces). 4. Enter the beneficiary's sex in Item 3 of Form CMS-1500 or the electronic claim equivalent (see Reference C). Valid values: Female (F) or Male (M).
Billing Provider Error:
The payment contractor-assigned group number/Provider Identification Number (PIN) of the billing provider is required. The group number/PIN is often incorrect or missing.
Resolution:
1. Verify the group number/PIN. 2. Enter the group number/PIN in Item 33 of Form CMS-1500 or the electronic claim equivalent (see Reference C).
Diagnosis Error:
ICD-9-CM diagnosis codes are required information. This information is often considered incorrect because the ICD-9-CM diagnosis code is missing or invalid.

Resolution:

1. Verify the ICD-9-CM diagnosis code.
2. Enter the ICD-9-CM diagnosis code, to the highest level of specificity (coding to the fourth or fifth digit), in Item 21 of Form CMS-1500. The principal diagnosis code is listed first and up to three additional claim ICD-9-CM code numbers may also be entered, or the electronic claim equivalent (see Reference C).

Late Filing Error:

Medicare claims must be filed within certain time limits or the service(s) will be denied.

Resolution:

Medicare law requires that a claim for services be filed no later than the end of the calendar year (CY) following the year in which the service was furnished, with the exception of services furnished in the last three months of the year. Services furnished within the last three months of a year must be filed by December 31st of the year following the year in which the services were furnished.
Example: October 1, 2002, through September 30, 2003, must be filed by December 31, 2004.

Modifier Errors:

Modifiers are two-digit codes that are entered on the claim form to modify payment of a procedure or to assist the Medicare payment contractor in determining appropriate coverage or otherwise identify the detail being billed. This information is often incorrect for the following reasons:

- An inappropriate modifier is used;
- An invalid modifier is used; or
- An appropriate modifier is missing.

Resolution:

1. Verify what modifier should be used, if any.
2. Enter the appropriate modifier in Item 24D of Form CMS-1500 or the electronic claim equivalent (see Reference C).

Note: Certain modifiers should **NOT** be submitted on Medicare Part B claims since they will be added during claims processing, if appropriate. These modifiers include 51, CC, XU, XW, XY, XZ, and XQ.

Procedure Code Error:

The services rendered are identified by HCPCS codes. This information is often incorrect because the HCPCS code(s) is missing or invalid.

Resolution:

1. Verify the HCPCS code(s).
2. Enter the HCPCS code(s) in Item 24D of Form CMS-1500 or the electronic claim equivalent (see Reference C).

Quantity Billed Error:

This value is the unit of services. The services must be equal to or greater than “1”. The services cannot be greater than “99”. The fourth position is an implied decimal. One unit equals “0010”. This information is often incorrect for the following reasons:

- The quantity billed is missing;
- The quantity billed does not correspond with the multiple visit dates entered;
- For anesthesia, the elapsed time (hours) has not been converted into minutes and the total minutes given for a procedure; or
- The provider billed multiple units for procedure codes that are not time-based.

Resolution:

1. Verify the quantity billed.
2. Enter the quantity billed in Item 24G of Form CMS-1500 or the electronic claim equivalent (see Reference C).

Performing Provider Number Error:

The carrier-assigned Provider Identification Number (PIN) of the performing provider is required for services rendered by a physician/supplier within a group practice. When several different providers of service or suppliers within a group are billing on the same Form CMS-1500, the individual PIN must be identified. This information is often incorrect for the following reasons:

- The performing provider PIN was missing;
- The performing provider PIN was entered incorrectly; or
- The performing provider PIN entered does not match the group practice number provided.

Resolution:

1. Verify the performing provider PIN.
2. Enter the performing provider PIN in Item 24K of Form CMS-1500 or the electronic claim equivalent (see Reference C).
3. When several different providers of service within a group practice are billing on the same claim, enter the individual PIN for each performing provider as it corresponds with the service rendered.

Place of Service (POS) Error:

This code identifies the location for each item used or service performed.

This information is often incorrect because the POS code is missing or invalid.

Resolution:

1. Verify the POS code.
2. Enter the appropriate POS code in Item 24B of Form CMS-1500 or the electronic claim equivalent (see Reference C).

Unique Physician Identification Number (UPIN) Error:

The (UPIN) and physician name is required information when a claim involves referring and/or ordering physician services. This information is often incorrect for the following reasons:

- The UPIN and provider name was missing; or
- The UPIN and physician name used is invalid for the services referred (e.g., chiropractic services, self-referred consultations).

Resolution:

1. Verify the referring provider's UPIN at the time of referral.
2. Enter the referring/ordering physician's name and UPIN in Items 17 and 17a of Form CMS-1500 or the electronic claim equivalent (see Reference C).
3. Ensure the UPIN and physician name are valid for referral of the type of service rendered.

SSA Coverage Policy Denial Information
Additional information regarding SSA coverage policy denials is available at http://www.ssa.gov/OP_Home/ssact/title18/1862.htm on the Web.

A provider must be aware of the following layers of coverage policy under Medicare:

- Statutorily excluded services;
- Regulations;
- National Coverage Determinations (NCDs);
- Coverage provisions in interpretive manuals; and
- Local Medical Review Policies (LMRPs) and Local Coverage Determinations (LCDs).

TOP COMPLIANCE ISSUES RESULTING IN CLAIM DENIALS OR CLAIM REJECTIONS

Patient coverage may be denied or the claim rejected for the following reasons:

- The patient is not entitled to Medicare services;
- The provider is not qualified to furnish the Medicare services billed;
- Medicare is the secondary payer to other insurance;
- Services are excluded by statute, national, or local coverage policy;
  - There is no benefit for the service;
  - The limited benefit is exhausted; or
- Claim/Services do not meet technical requirements for payment (including national and local requirements). These include, but are not limited to:
  - Certification;
  - Plan of care;
  - Certificate of Medical Necessity (CMN) for Durable Medical Equipment (DME); and
  - Compliance with Correct Coding Initiative (CCI) edits.

WHEN THE PATIENT IS NOT ENTITLED TO MEDICARE SERVICES

A provider or supplier should determine a patient's eligibility before providing services to help prevent a claim denial or claim rejection because the patient is not entitled to Medicare services. The provider or supplier can determine eligibility by obtaining a copy of the beneficiary's red, white, and blue Medicare card during his or her first visit and confirming eligibility for the services to be furnished and billed.

What is NOT Covered by Medicare

The following general medical services are not covered under Medicare Part A or B:

- Acupuncture;
- Ambulance transportation to a doctor's office;
- Blood transfusions after the first three pints of blood;
- Cosmetic surgery unless it is needed to improve function of a malformed part of the body that was accidentally injured;
- Custodial care at a nursing home whenever this is the only kind of care required by the patient;
- Routine dental care or most dental procedures such as cleanings, fillings, tooth extractions, dentures, dental plates, or other dental devices;
- Emergency inpatient services in foreign countries except for some instances in Canada and Mexico to include:
  - When the patient is traveling within the U.S., a medical emergency occurs, and the closest hospital that can provide adequate treatment is in either Canada or Mexico;
  - When the patient is traveling through Canada without unreasonable delay by the most direct route between Alaska and another state and a medical emergency occurs and the Canadian hospital is closer than the nearest U.S. hospital that can treat the emergency; or

- The patient lives in the U.S. and the Canadian or Mexican hospital is closer to the patient's home than the nearest U.S. hospital that can treat the medical condition, regardless of whether an emergency exists.
- Routine eye exams;
- Routine foot care;
- Health and wellness education;
- Routine hearing exams;
- Private nursing duty, television, or telephone in a patient's inpatient hospital room;
- A private room in a hospital unless it is deemed medically necessary;
- Custodial care;
- Medical Nutritional Therapy (MNT) services if the patient has diabetes or kidney disease but is on dialysis;
- Transportation to receive routine health care; or
- Workers' Compensation (WC) claims.

The following general items are not covered under Medicare Part B:

- Bathroom supplies such as tub railings;
- Blood pressure monitor (unless the patient is receiving home dialysis);
- White canes for the blind;
- Hearing aids;
- Experimental items during a clinical trial providing and testing new types of medical care;
- Diabetic supplies not ordered by the physician;
- Diabetic supply refills sent automatically by a supplier to the patient;
- Diabetic supplies such as insulin (unless used with an insulin pump), insulin pens, syringes, or needles;
- Adult diapers;
- Common medical supplies such as alcohol swabs, bandages, and gauze;
- Supplies and/or DME provided by a supplier that is not currently enrolled in Medicare and does not have a current Medicare supplier number, even if the supplier is a large chain or department store that sells more than just DME;
- DME that is used in a Skilled Nursing Facility (SNF);
- Eyeglasses (except for one pair of standard frames, intraocular lenses, or contact lenses after cataract surgery);
- Portable oxygen when provided as a backup to a stationary oxygen system or used in an SNF;
- Most outpatient prescription drugs **except for** some antigens, osteoporosis drugs (covered while receiving home health care), Epoetin alfa (Epogen®), hemophilia clotting factors, immunosuppressive drugs, oral cancer drugs (if available in injectable form), and oral anti-nausea drugs;
- Orthopedic shoes and shoe inserts unless they are a necessary part of a leg brace and the cost is included in the charge for the brace;
- Outpatient substance abuse treatment if the treatment center does not participate in Medicare;
- Surgical stockings;
- Wheelchairs if the patient is able to walk, but has difficulty walking long distances;
- Wheelchair ramps, elevators, stair glides, or some other lift devices; or
  Note: Some lift chairs and chair lift mechanisms are covered.
- Wigs.

WHEN THE PROVIDER IS NOT QUALIFIED TO FURNISH THE MEDICARE SERVICES BILLED

A provider billing office must be aware of the status of not only their billing provider number, but whether all physicians and clinicians furnishing and billing for Medicare covered services through the provider PIN are legally able to participate in the Medicare Program. It is the provider's responsibility to assure that he or she does not bill Medicare for services furnished by “excluded” individuals. For additional information regarding how providers can identify “excluded” individuals so that if they are employed within the provider's office they will not provide any Medicare services, refer to Part 4, Payment Denials Due to Exclusion.

MEDICAL NECESSITY ISSUES

Errors in compliance with medical necessity policy may be identified by payment contractors either by automated systems that use logic programming to match code combinations (e.g., ICD-9-CM codes with HCPCS codes) or through manual MR. Medical necessity denials are all supported in statute under Section 1862(a)(1)(A) of Title XVIII of the SSA. Denials based upon medical necessity determinations can always be appealed.

Payment contractors [carriers and fiscal intermediaries (FIs)] and program safeguard contractors (PSCs) are responsible for determining medical necessity. A description of local coding and documentation requirements that are used to determine that that services furnished and billed for were medically necessary is located in the Local Medical Review Policies (LMRPs).

SSA Medical Necessity Denial Information
Additional information regarding medical necessity denials supported by the SSA is available at http://www.ssa.gov/OP_Home/ssact/title18/1862.htm on the Web.

Medicare Coverage Database Containing LMRPs and LCDs
The LMRPs and LCDs are available in the Medicare Coverage Database at http://www.cms.hhs.gov/mcd on the Web.

If a provider's or supplier's claim is denied based on medical necessity, the applicable LMRP or LCD should be reviewed for additional information.

The following section highlights the most common reasons for medical necessity denials and provides suggestions for resolving the issues and preventing future denials for medical necessity reasons.

TOP COMPLIANCE WITH MEDICAL NECESSITY ISSUES - RESULTING IN CLAIM DENIALS OR CLAIM REJECTIONS

The following compliance issues could result in a Part B claim denial or claim rejection:

- The HCPCS code is not medically necessary to treat the ICD-9-CM diagnosis code;
- HCPCS code is billed at a frequency that is considered not medically necessary;
- The treatment furnished is considered to be beyond acceptable attainment of goals or is for maintenance purposes; or
- Insufficient documentation.

WHAT DEFINES A CLAIM THAT CANNOT BE PROCESSED?

A claim that cannot be processed was submitted but was missing information that is required for processing. Any paper claims that cannot be processed are returned to the physician or supplier through the Remittance Notice. The Remittance Notice will contain messages that describe what required information is missing, thus making it unable to be processed. To correct a paper claim that cannot be processed, the physician or supplier's office must submit a corrected claim for processing.

HOW ARE CLAIMS RETURNED?

When Form CMS-1500 is returned with a cover letter explaining what information is missing, a corrected claim must be re-filed by the physician or supplier. These claims cannot be entered into the system for processing until the requested information is included and resubmitted on Form CMS-1500. If the physician or supplier needs additional information or assistance with providing the appropriate information, call the contractor's customer service line.

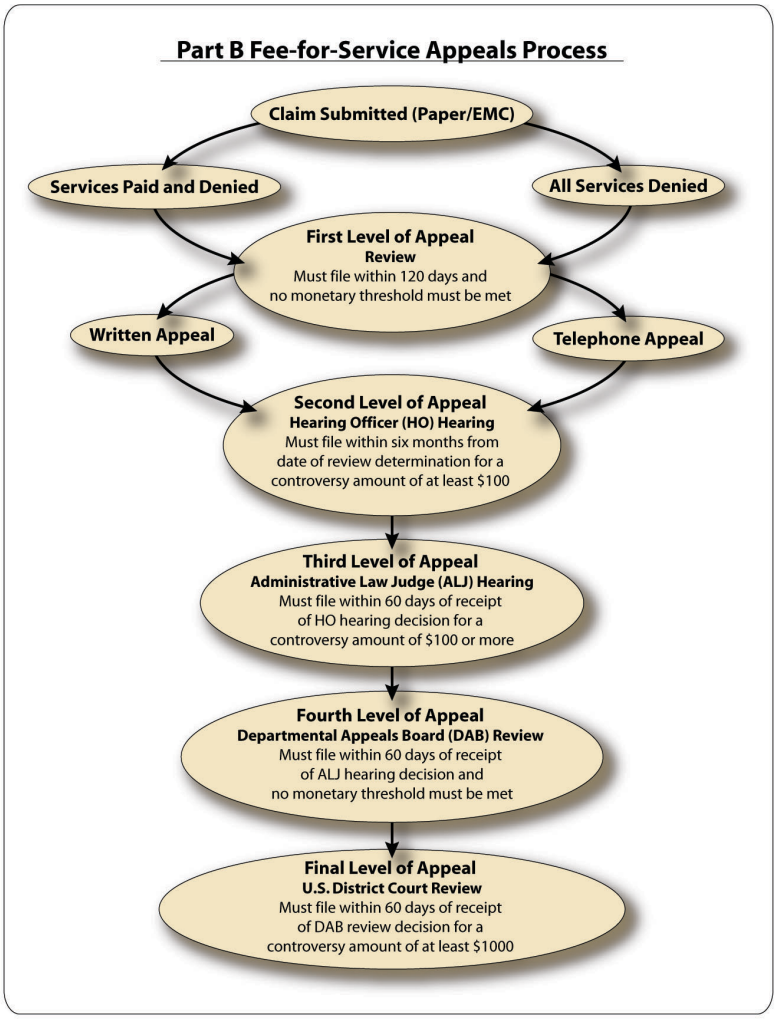
HOW CAN PART B CLAIM DENIALS BE APPEALED?

The current Part B fee-for-service appeals process is depicted in Figure 5-1. Please note that this appeals process is being updated as a result of recent changes in Medicare law. Before initiating an appeal, providers should confirm the current process (including time limits and monetary thresholds with their carriers).

FIRST LEVEL OF APPEAL - REVIEW

After the initial determination has been made on a Part B claim, the first level of appeal is a review. A review is a second look at the claim and supporting documentation by a different employee. A review request can be made either in writing or by telephone.

Figure 5-1. Part B Fee-for-Service Appeals Process.



Current Appeals Policy Information

Current appeals policy can also be located in Chapter 29, Section 60, of the *Medicare Claims Processing Manual*, available at http://www.cms.hhs.gov/manuals/104_claims/clm104c29.pdf on the Web.

WRITTEN REVIEW REQUEST

The purpose of a written review request is to contest the initial determination made on a Part B claim. A written review request must be filed within 120 days of the date of the initial determination for claims that were processed after September 30, 2002. No monetary threshold is required to be met. Section 1842(b)(2)(B)(i) of the Social Security Act requires that 95% of all review requests be completed within 45 days of the date the request is received.

The following information must be included within a written review request:

- The beneficiary name and HICN;
- The physician or supplier's name and address;
- The date of initial determination;
- The date of service for which the initial determination was issued; and
- The signature of the appellant.

If any of the above-listed information is missing from the written review request, the review request will be returned to the physician or supplier with an explanation of what must be included. Since most of this information is found within Form

Where to Obtain a CMS 1964 Request for Review Form

A CMS 1964 Request for Review form can be ordered from the contractor or downloaded at http://www.cms.gov/forms/cms1964.pdf on the Web.

CMS-1500 and the Medicare Remittance Notice (MRN), the relevant information may be highlighted on the forms and they may be filed together with a signed review request and an explanation for the request.

Helpful Hints for Filing a Written Review Request

It is very helpful and sometimes necessary to submit an indication of why the service should be paid. It is especially helpful to include any documentation that would be needed to conduct the review. Supporting documentation may include, but is not limited to:

- Operative notes;
- Progress notes;
- Office notes; or
- A letter from the physician.

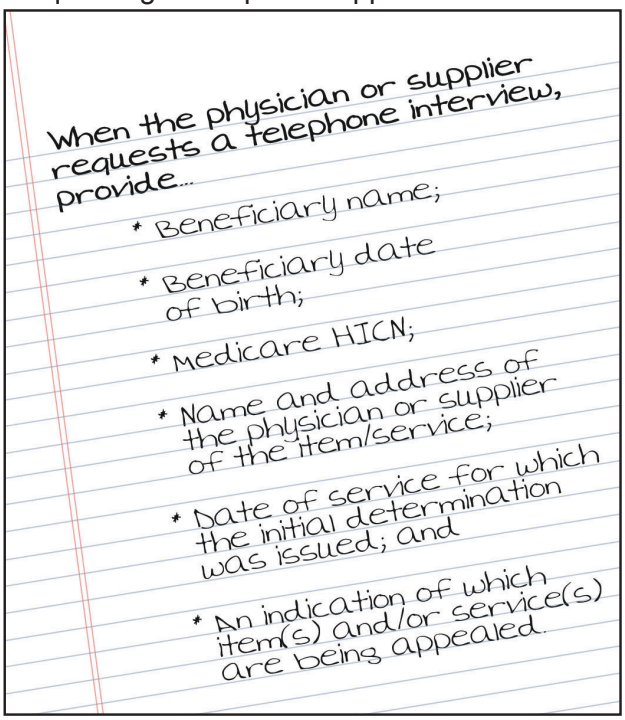
If documentation that is needed to make a review determination is not included with the request, it may be requested from the physician or supplier. The physician or supplier will be given 14 days to provide the requested documentation.

When a party requests a review of an assigned claim, the physician or supplier, and the patient, will be notified of the review determination because both are parties to the appeal. This notification will be in the form of a letter, a revised Medicare Summary Notice (MSN), or an MRN. If all services in question are paid, then the parties will receive a revised MSN or MRN; however, if any service in question is partially or fully denied, the review determination will come in the form of a letter. The physician or supplier can make a review request for a non-assigned claim if the beneficiary completes and signs the Appointment of Representation Form (Form CMS-1696), or if he or she is required to provide a refund to the beneficiary pursuant to Section 1842(l) of the Social Security Act.

TELEPHONE APPEALS

Review requests are accepted over the telephone at some contractors; however, the type and complexity of the issues involved in the review will determine if the request will be completed as a telephone review or transferred to the written review department for completion. See Figure 5-2 for a checklist of information a requestor must provide when requesting a telephone appeal.

Figure 5-2. Information Checklist for Requesting a Telephone Appeal.



The following list provides examples of the reviews that can be conducted by phone:

- Number of services/units;
- The addition, changing, or deletion of certain modifiers;
- ICD-9-CM diagnosis codes;
- Erroneous denials (duplicates);
- Procedure codes;
- POS codes; and
- Dates of service.

Note: Proof to support a verbal review request made on behalf of a beneficiary must be submitted via fax. Any requested supporting documentation must be faxed within 48 hours of the request for the phone review, and within 14 days for reviews that are transferred to the written appeals area. When documentation is faxed, it must reference the confirmation/control number assigned to the appeal. If the requested documentation is not received with the stated timeframes, the appeal decision will be based on the information in the file.

The following types of reviews are always inappropriate for a telephone appeal:

- Claims requiring input from the medical staff or entities outside the Appeals Unit [e.g., Operative Report, CMS, Common Working File (CWF) System, provider enrollment]; and
- Claims submitted with the incorrect billing provider name or number (Item 33 on Form CMS-1500).

SECOND LEVEL OF APPEAL - HEARING OFFICER (HO) HEARINGS

An HO hearing is the second level of appeal for participating physicians, suppliers, and beneficiaries who are dissatisfied with their review determination. Section 1842(b)(2)(B)(ii) of the Social Security Act requires contractors to make a final determination for 90% of all HO hearings within 120 days of receipt of the hearing request.

The following requirements must be met to receive an HO hearing:

- A request for hearing must be in writing and signed by the requestor;
- The request must be filed with CMS, the contractor, or an office of the Social Security Administration (SSA) or Railroad Retirement Board (RRB) within six months of the receipt date of the review determination; and
- The amount in controversy must be at least $100.

A letter acknowledging receipt of the hearing request will be sent within 21 days of receipt of the request. If the request was not made in a timely manner or does not meet the amount in controversy requirement, it will be dismissed and a letter will be sent explaining the reason for the dismissal.

The following three types of HO hearings are available to the requestor:

- **In-Person Hearing** - The requestor or his or her representative has an opportunity to appear in-person in front of an HO and present information supporting the claim and challenging the information the contractor used to reach the previous determination. The hearing will be held at a location that is reasonably convenient for the appellant and the HO.
- **Telephone Hearing** - A telephone hearing differs from an in-person hearing in that the hearing is conducted entirely over the telephone, rather than in person. The appellant and/or his or her representative, may also submit additional written evidence by mail or facsimile.
- **On-The-Record (OTR) Hearing** - If the requestor chooses not to appear in person or have a hearing by telephone, he or she may choose an OTR hearing. In an OTR hearing, the requestor will not present oral testimony. The major advantage of an OTR hearing is that a decision will be quickly rendered to the requestor based on the facts in the file and any additional information that was submitted to the HO. If documentation is not included in the request that is needed to make a determination, the information may be requested from the physician or supplier.

If the requestor specified the type of hearing preferred, no further action is required on his or

her part unless the HO assigned to the case contacts him or her.

If the type of hearing is not specified by the requestor, the acknowledgment letter will provide him or her with an available choice of hearings. The requestor must choose a hearing type and return the letter as soon as possible. Alternatively, the HO may contact the requestor by telephone to determine the type of hearing that he or she wishes to have.

THIRD LEVEL OF APPEAL - ADMINISTRATIVE LAW JUDGE (ALJ) HEARING

If a party to the HO hearing is dissatisfied with the decision and the amount in controversy is $100 or more, the party can request a hearing before an ALJ. The request must be submitted within 60 days of his or her receipt of the HO's decision. This function is currently performed by ALJs employed by the SSA's Office of Hearing and Appeals (OHA). The ALJ hearing results in a new decision by an independent adjudicator.

HOW TO REQUEST A PART B ALJ HEARING

To request an ALJ hearing, the requestor must file a written request for a Part B ALJ hearing with the Medicare contractor, CMS, or at an office of the SSA or RRB, within 60 days of the date of his or her receipt of the HO's decision. If a request is sent directly to the carrier or FI, the request will be forwarded with the case file to the SSA/OHA Division of Medicare - Part B. Once an ALJ hearing has been requested, the ALJ obtains jurisdiction over the case.

FOURTH LEVEL OF APPEAL - DEPARTMENTAL APPEALS BOARD (DAB) REVIEW

After a decision has been made by at an ALJ hearing on a Part B claim, the next level of appeal is a DAB review. A request for DAB review must be made within 60 days of receipt of the ALJ's decision. No monetary threshold is required to be met. The request may be submitted by letter or by using the Request for Review Form (DAB-520). See Figure 5-3 for a checklist of information a requester must provide when requesting a DAB Review.

If a requestor is dissatisfied with the DAB's decision, he or she must then commence civil action and request a Federal District Court hearing within 60 days of receipt of the DAB's decision. The requestor must file the complaint with the U.S. District Court, not the carrier. The U.S. District Court may remand the case to the DAB or ALJ for further proceedings.

How to Contract the ALJ
After the ALJ assumes jurisdiction over a case, all inquiries should be submitted to the following address:

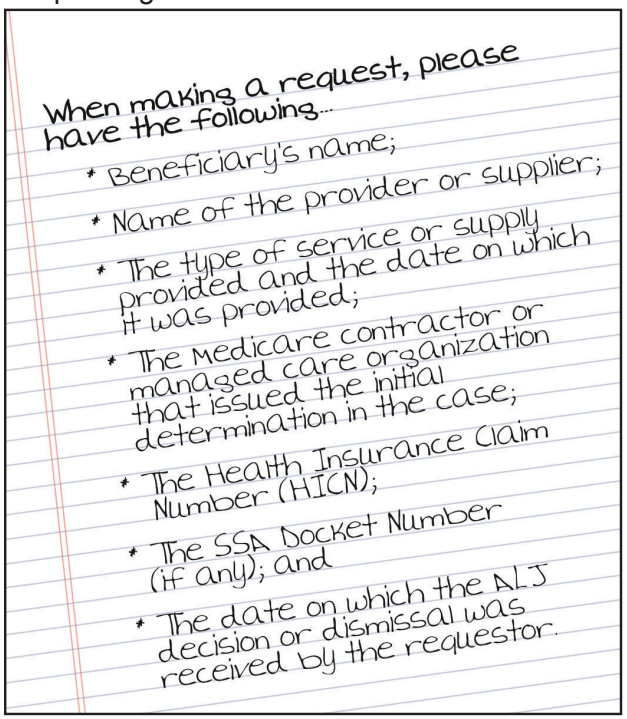
SSA/Office of Hearings and Appeals
Division of Medicare - Part B
5107 Leesburg Pike, Suite 502
Falls Church, VA 22041-3255

Phone inquiries pertaining to the status of a request for a Part B ALJ hearing should be made to the Division of Medicare - Part B at 703-605-8550.

Where to Submit a DAB Request for Review
A request for DAB review should be submitted to the following address:

Department of Health and Human Services
Office of the Secretary
Department of Appeals Board, MS6127
Medicare Appeals Council
Cohen Building, Room G-644
300 Independence Avenue, S.W.
Washington, D.C. 20201

Figure 5-3. Information Checklist for Requesting a DAB Review.



FINAL LEVEL OF APPEAL - FEDERAL DISTRICT COURT REVIEW

If a requestor is dissatisfied with the DAB's decision, he or she must then commence civil action and request a U.S. District Court hearing within 60 days of receipt of the DAB's decision. At least $1,000 must remain in controversy. The requestor must file the complaint with the U.S. District Court, not the carrier. The U.S. District Court may remand the case to the DAB or ALJ for further proceedings.

HOW ARE NCDS AND LCDS REVIEWED?

On December 8, 2003, CMS implemented a new process that permits certain Medicare beneficiaries to challenge coverage policies that may prevent access to items and services or that have resulted in claim denials. These changes were required by Congress per Section 522 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act (BIPA) of 2000. With this new policy, a beneficiary who qualifies as an "aggrieved party" may challenge an LCD or an NCD (or specific provisions therein). Medicare defines an "aggrieved party" in 42CFR §426.110 as follows:

Aggrieved party means a Medicare beneficiary, or the estate of a Medicare beneficiary, who:

(1) Is entitled to benefits under Part A, enrolled under Part B, or both (including an individual enrolled in fee-for-service Medicare, in a Medicare Advantage Plan, or in another Medicare managed care plan);
(2) Is in need for coverage for a service or item that is denied based upon an applicable LCD (in the relevant jurisdiction) or an NCD, regardless of whether the service or item was received; and
(3) Has obtained documentation of the need by the beneficiary's treating physician.

How to Challenge an LCD or NCD

A beneficiary that qualifies as an aggrieved party may challenge an LCD or an NCD by filing a complaint with the office designated by CMS. Beneficiaries may obtain information regarding how to file a complaint by calling the toll-free 1-800-MEDICARE (1-800-633-4227) line. For TTY services call 1-877-486-2048.

How to Challenge an LCD or NCD if Only a Beneficiary can Submit a Request for Review

Providers may continue to participate in the process of developing, revising, or discontinuing an LCD or NCD under existing policies. Part 4, Benefits to Medicare Providers and Suppliers, addresses the policy development process. Procedures for challenging an NCD are located at http://www.cms.hhs.gov/coverage on the Web. Your carrier can provide information regarding how to challenge an LCD/LMRP.

Beneficiaries that have had claims denied that are based upon an LCD or an NCD will have the following message on their MSN:

15.20 - The following policies [carrier-inserted applicable LMRP ID# and/or NCD #] were used when we made this decision.

Note: LMRPs contain LCD policies and often other information such as procedure coding and payment instructions that are not part of an LCD.

In this process, an aggrieved party may not assign legal rights to request a review of an LCD or an NCD to a third party (including a provider). However, a provider is permitted to assist the beneficiary in developing the initial request for review and in navigating the review process. This involvement of a third-party to offer assistance is not mandatory, and unless a provider is subpoenaed under existing regulations, there will be no monetary expenses reimbursed by Medicare.

CMS does not believe that the provisions of this new process will have a significant effect on providers since Congress developed the BIPA 522 policy review process for beneficiaries. Providers may be requested, however, to supply documentation that an aggrieved party is in need of that pertains to a specific service, and to assist in representing an aggrieved party. In addition, the documentation necessary for the review may be in the form of an order or other existing language from the beneficiary's medical record, and need not be newly-created material. Overall, CMS believes that this rule will result in an insignificant economic impact on healthcare providers or the healthcare industry as a whole.

A favorable decision for the beneficiary may result in a previously denied claim being paid by Medicare. In addition, this process may result in a policy change in an LCD or NCD that will affect other beneficiaries in the future. However, the right to challenge NCDs and LCDs is distinct from the existing appeal rights for the adjudication of claims discussed in Part 5, Final Level of Appeal - Federal District Court Review. Thus, a beneficiary may elect to pursue a claims denial through the claims appeal process, seek review of an LCD or an NCD using this process, or both.

NOTES